PLAINTIFF'S EXHIBIT D

IN THE UNITED STATES DISTRICT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

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LATHIERIAL BOYD,
Plaintiff,
vs. Case No. 13 C 7152
CITY OF CHICAGO, et al.,
Defendants.

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Videotaped Deposition of
PAUL R. MEYER, JR., M.D.

April 22, 2016
10:52 a.m.
Taken at:
GREENBERG TRAURIG, LLP
77 West Wacker Drive, Suite 2500
Chicago, Illinois

JENNIFER L. BERNIER, CSR, RPR, CRR

his own so you can't put your finger over a tube.

Q. So my confusion, I guess -- he can't breath on his own. I understand that. And so he's on the ventilator, which I thought is the thing that's helping the patient inhale because this patient can't inhale.

A. That's correct.

Q. But, as I understand it, you're saying, but you still need some sort of external pressure, like pushing the chest, or bagging, or something?

A. We live in one atmosphere pressurewise. So when we breath, we forcefully inhale. And what's happening is, the diaphragm is contracting and pulling air in. But in the one atmosphere in which we live on earth, the chest just automatically closes by itself, so the air comes out.

Q. It's a passive event, exhaling?

A. It's a passive event. So it's an active event to get the air in. It's a passive event when it's coming out. But the patient has no muscle contraction, so the air would be

ineffectual in verbalizing. So you have to take whatever the air is in the lung and push it out so that it goes by the vocal cords.

Q. So it's not a natural event, once the cuff is deflated, for the air to naturally direct itself past the vocal cords to create that audible sound?

A. That's right. It's not a natural event. The patient can't -- see, you and I would use our abdominal muscles, you know, to strain. And what we do is, we use our abdominal muscles to push the air out.

But this patient has no motor or sensory function below this level. So he can't push any of the air that went into the lung out except just it just seeps out. There's no force to it. And without force, you can't verbalize.

So you would have to have someone standing at the bedside, a trained respiratory therapist or a trained nurse, to push on the abdomen and to push on the diaphragm to force whatever air there is in the lung out for a patient to verbalize.

Now, that wouldn't happen with the standard tracheostomy tube. It would only happen with a fenestrated tube.

Q. What kind of tube did Mr. Warner have?

A. He had a standard tube; a standard tracheostomy tube, not fenestrated.

Q. Fenestrated, meaning there's little holes in the tube?

A. Holes in the tube.

Q. And did you see something in the records that indicated that Mr. Warner had a standard tube?

A. All I read about was a standard tube.

Q. So this whole process that you're discussing about Mr. Warner's -- strike that.

This whole process you're discussing about a quadriplegic potentially being able to verbalize with the cuff deflated, in this process that we've talking about, you're saying can only happen with a fenestrated tube; is that right?

A. A fenestrated tube and a tube where

the tube can be -- the cuff can be deflated so that the air can pass through either around and through the fenestrated tube getting air across the vocal cords.

Q. Would you expect that Mr. Warner, as time went by, got stronger and that he may have been able to verbalize later on in his life?

A. Well, that's a hypothetical question because I do not have any information about Mr. Warner after he departed the hospital to Oak Forest. So knowing what I know right now, I would say that it would be very unlikely unless he had some sort of support to verbalize, external support to verbalize.

Q. Right. Still ventilator-dependent?

A. Still.

Q. But, perhaps, with some -- what would be the external support that he would need; is it what we've been talking about?

A. Having a respiratory therapist, or a nurse, or someone to push on his abdomen and push the air out of his lungs so that the air went through the trachea and by way of the

that.

On page 2 of Exhibit 2, it says, It is his opinion that Ricky Warner's primary way to communicate was to mouth words and blink his eyes. Do you see that?

A. Yes. That was -- that's two ways; to blink his eyes, mouth his mouth, and to move his head around side to side.

Q. And it says primary way. I know that you didn't write this, but is it your opinion that there were other ways he could communicate besides the three that you've just described?

A. No.

Q. Back in March, early March of 1990, what sorts of things do you believe Ricky could communicate?

A. I have no idea. He was never communicating except by mouthing, if that's what you mean.

Q. I guess I'm trying to get a sense of, do you think -- do you think that Mr. Warner's cognitive ability was impaired in any way?

A. Absolutely not.

Q. Why do you say that?

A. Well, first of all, stop and think for a moment that he received a gunshot wound to the neck and wasn't breathing for probably several minutes. Let's just say that it took five minutes for the ambulance to get to him. There's five minutes where he went without breathing.

The patient had, according to his medical records, a history of drugs, cocaine, heroine, and other drugs. That would alter his mental status. The patient had extreme frustration with his inability to control any, any, of his environment. The patient, at some particular point in time, was found to be disconnected from his ventilator, and that would produce a second opportunity for loss of ability to breath for a variable period of time.

So the overall answer to your question is, yes, he had altered mentation.

Q. What does that mean? Can you define that for me, altered mentation?

A. He wasn't able to think clearly. I apologize for that.

Q. So in light of your opinion that he had altered mentation, what sorts of things do you think Ricky could communicate in March of 1990?

A. I think we've been talking about the fact that he couldn't communicate except by mouthing all along.

Q. Right. And I don't mean the mechanics. I think I mean more conceptually. Are there certain things you feel that he could understand and certain things he couldn't understand because of his altered mentation?

A. Well, if you have reviewed his records day by day by day by day by day, you would find, as I noted a moment ago, that he had an extremely high level of anxiety, an extremely high level of anger, an extremely frustrating inability to control any of his bodily functions any longer, was very often abusive to the people who were trying to take care of him, used, apparently, foul language by mouthing, and eventually even had to be

seemed to me that a psychiatrist noted, in the psychiatric report, that he had some alteration in his behavioral traits before he was admitted. I could be in error there.

Q. Okay. But aside from potentially a psychiatric record, you don't have any knowledge of what Mr. Warner was like before he was shot and admitted into Northwestern Hospital?

A. No.

Q. Do you think that Mr. Warner, his memory was impaired?

A. You asked me that. I said, yes.

Q. I don't think I asked you about his memory.

A. Well, that's part of --

Q. But I apologize if I did.

A. -- that's part of mentation, okay --

Q. Okay.

A. -- his ability to think.

Q. Okay. It has been opined in this case that Mr. Warner could only communicate on a very basic level -- I'm summarizing. I

appreciate this isn't word for word -- but that he could communicate that he was hungry, that he was in pain, that he was sad, that he was tired. But he couldn't have higher-level discussions. Would you agree with that --

A. I do.

Q. -- assessment?

And when you say that his memory was impaired, can you just provide a little bit more detail for me so I understand the degree to which Mr. Warner's memory was impaired?

A. No. As a physician, I didn't give him any testing to determine any of those characteristics that one would go through psychologically to test ones memory. So the answer is, no, I cannot.

Q. So what's your basis for determining that Mr. Warner's memory was impaired?

A. Well, he was off the ventilator between the time he was shot and the ambulance arrived, which was a loss of probably some central nervous system function. And I would -- at this point, it would be cerebral

function, and that he was disconnected from the ventilator on another occasion, which would be cerebral insult, and that he had a projected period where it was known that he was on drugs, which would be another reason for altered ability.

Q. And you're referring to the heroine and the cocaine that you testified to earlier?

A. As read in the chart.

Q. Do people who take heroine and cocaine, does that affect their memory in the long term?

A. Doesn't the TV say all of the time you're burning your brain up when you're taking heroine and cocaine? I mean, I think the knowledge is out there --

Q. So that's a yes?

A. -- it's destructive to brain function.

Q. Okay. So, presumably, he had some sort of sensory impairment as a result of this drug use prior to the shooting. Is that your opinion?

A. I cannot vouch for the remainder,

communication patterns?

A. Yes.

Q. Could you describe the style of communicating that you're talking about, or are you just strictly talking about mouthing?

A. For the record, I'm only -- everything that I'm saying is mouthing.

Q. Okay.

A. For the record.

Q. Thanks for clarifying that. Because when I read this, it just struck me that communication patterns -- I thought maybe there was a reference to something broader than that. But it's just mouthing?

A. That's mouthing on the part of the patient.

Q. Right. And the nurse would be talking. Is it your opinion that only nurses could understand the mouthing, or could others understand it, too?

A. It's very, very, very, very difficult for a neophyte, an individual, even a parent, to attempt to talk to a loved one who is in this condition and understand anything

that they're saying. And the nurses who are at the bedside 24 hours a day develop a second sense as to what the patient is saying when they're attempting to communicate by mouthing. It's almost being intuitive.

Q. I see. Did family members of quadriplegics -- over the course of your career, could family members ever speak with their loved ones? Did you ever witness that?

A. Of course.

Q. So it was probably more difficult for them, but it was possible?

A. Well, you asked me did I ever find where family members spoke with the patient. The family members had no speak -- no problem speaking.

Q. Okay.

A. The problem is in the interpretation of what the patient is saying, and that's what the nurses develop intuitively is the ability to interpret what the patient is trying to impart.

Q. Did you ever witness non-nurses, such as family members or friends, communicate

with your quadriplegic patients effectively?

A. Oh, myself. Even myself, when I would attempt to have some sort of discussion between myself and a patient, it had to be at the very basic, basic level because, A, the patients could not carry on a conversation; B, they were on a ventilator; C, they were unable to verbalize. The only thing they could do was mouth.

And I have never really been taught to mouth read before. It's almost like understanding hand signs. You have to be trained to sort of do it for a while, and that's what the nurses developed.

Q. Can you do one thing for me? Can you flip through here -- and I'm going -- I'll go ahead and mark this.

THE REPORTER: 4.

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(Thereupon, Deposition Exhibit 4, Consultation Records, was marked for purposes of identification.)

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Q. Can you flip through here? And

you know, how a patient is doing, essentially, how they're progressing?

A. Well, I would do a neurological. I would do chemistry tests. I would do respiratory tests. I would do a discussion test. You know, all of those things go into the assessment of the patient.

Q. Tell me about those discussion tests.

A. The what?

Q. Discussion tests.

A. Well, you and I -- you're testing me right now. I'm having a discussion with you, so I would have a discussion with the patient.

Q. And the patient -- if the patient was a quadriplegic, they would respond back to you by mouthing words, correct?

A. They would do it on the very basic level.

Q. And, generally, you were able to complete these assessments in a way that was satisfactory to you; is that right?

A. No. It would never be satisfactory

and they have to be sucked out to get those secretions out.

Q. Got it.

A. You know, it's very, very difficult. I'm speaking from me.

Q. Right. Just in your experience?

A. In my experience.

Q. If a nurse were to deflate the cuff of a quadriplegic patient at Northwestern back in March of 1990, would you expect the nurse to make a note of that in the progress --

A. Yes.

Q. -- report?

Did a nurse have to seek permission from a physician before they did something like that?

A. Yes.

Q. You've spoken a couple of times about Mr. Warner becoming disconnected from the ventilator in March. Do you remember that?

A. I do.

THE REPORTER: This is 5.

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(Thereupon, Deposition Exhibit 5,

Q. Does it say anything else? Are there any specific medical details that are provided in Exhibit 5 that you could summarize for me?

A. Well, I'm not sure what it is that you're looking for or at.

Q. I'm just looking for you to tell me what this says.

A. Yes. It says, Call to see if the patient became disconnected from the ventilator unnoticed. Secondary era. Alarm malfunctioned for one or two minutes per the nurse. In arriving, the patient awake. And I don't know what the next couple of words are. AMBU bag, ventilated. So they had to connect him up to a bag and ventilate him under pressure.

Q. Does this -- I'm sorry. Were you done?

A. I am.

Q. Does this record indicate whether or not Mr. Warner lost consciousness?

A. It does. It does reveal that he had a significant alteration in his mentation at this particular episode because there was a

Q. Well, that was going to be my question. What was your takeaway? What was your conclusion?

A. I've asked that question all along. Why am I here?

Q. And --

A. I don't know where you want to go. I have no idea.

Q. Did they ask you specific questions? You know, did you have any sort of follow-up, Hey, Dr. Meyer, what did you think, or can he phonate, or --

A. No. I've answered that repeatedly over and over. He couldn't phonate.

Q. Right. But my question is, did you ever have some discussions about your conclusions with Ms. Zellner's office? I mean, presumably, you said they provided this to you at some point. So there had to have been --

A. Yeah. I suspect, in the discussion of could he phonate, the answer is, res ipsa loquitur. It's right here before you. I don't think that he could phonate. And I know he never had a PEG. And I know that they never

deflated his cuff. And those are my -- those are my opinions.

Q. And to that point, looking at page 2 on Exhibit 2, I think the second-to-last sentence says, Dr. Meyer will testify to his opinion that if a PEG is surgically implanted, the cuff can be deflated and the patient can phonate. Do you see that?

A. Yes.

Q. But that's not quite accurate, right? If I understand your testimony earlier, you said that surgical insertion of the PEG is unrelated to deflating the cuff, right?

A. Well, you put in a PEG so that you're not ever going to have food going down into the trachea. So they're related in that you don't want the patient to drown in his fluid, own fluids.

Q. But you can -- and correct me if I'm wrong. I just want to make sure I understood you earlier correctly. I thought you had said that you can deflate the cuff and you can assist a ventilator-dependent patient to phonate?

A. If he had a fenestrated tube --
Q. Right.
A. -- which he didn't have.
Q. Right. But without the PEG? You don't need the PEG for that?
A. You don't need the PEG for that.
Q. Did Ms. Zellner's office ever provide you a copy of the complaint?
A. I don't -- I don't think so. I don't think that I've got -- got the complaint.
Q. And have you independently done any research about the underlying facts of this case?
A. Yes.
Q. What did you do?
A. I pulled up the patient's name, the plaintiff in this case's name on the Web, to get some background information, and that's where I got my education.
Q. What sorts of documents on the Web did you review?
A. What is it, Guardian, Guardian News?
Q. Did you review anything else?

A. No. I didn't have anything else.
Q. And did you do that on your own volition, or did someone suggest that you look that up?
A. My daughter suggested that I look it up.
Q. Is it your opinion that what you read, in that Guardian Newspaper Website, was accurate, or do you have an opinion on that one way or the other?
A. Well, that's a loaded question. You know, one and one is still two. And so here was an individual who was accused and then the same individual was exonerated, so you draw some conclusions. And from -- as a result of that, I've drawn some conclusions, but that's where I got my information.
Q. What sorts of conclusions have you drawn?
A. That Mr. Boyd was wrongfully identified.
Q. By whom?
A. Well, I would say, from the medical records, that the question exists as to who

pointed out Mr. Boyd because I could find no evidence, in the medical -- in the medical nursing progress records, that anyone had ever come to the patient's bedside and had Mr. Warner point out Mr. Boyd.

Q. Did you get -- you didn't receive any trial testimony transcripts, did you?

A. Trial testimony?

Q. From Mr. Boyd's criminal trial?

A. No. No.

Q. You didn't get any of those?

A. No.

Q. Okay. So you weren't aware that a nurse who was there when the police officer were there testified at Mr. Boyd's criminal trial?

A. I never saw any nursing note at all, in the nursing records at Northwestern Memorial Hospital, that an officer was at the bedside.

Q. Do you -- does that cause you to question whether or not the officers were ever at the bedside? Is that something --

A. I'm just telling you that I've